The Faces of Care

It takes a team to care for patients: profiles of essential teams to care for 47,000 people
It Takes a Team to Care for Patients

The release of the discussion paper, *Patients First: A Proposal to Strengthen Patient-centred Health Care for Ontario* by the Ministry of Health and Long-Term Care (MOHLTC) on December 17, 2015, affords an opportunity to provide this overview of our organization.

We believe it’s important that decision-makers understand what is required to care for 47,000 patients today and the forecasted exponential growth of patients in the future. The teams of the Mississauga Halton CCAC are on the front-line of patient care and that insight is necessary to implement the proposed structural changes.

It takes leadership and vision to build great teams. Our teams champion collaborative relationships throughout our organization and with the Mississauga Halton LHIN, as well as with primary care providers, community organizations and hospitals. Those partnerships result in better outcomes and experiences for patients and their families and for Ontario’s health care system.

This booklet introduces each of our 23 inter-connected teams. Organization charts and boxes alone cannot show how teams work together to deliver care. The team profiles presented here provide an organizational overview of how each of our teams collaborate to care for 47,000 patients and the residents of this region and complements our formal response to the MOHLTC’s discussion paper.

Our intent is to present the faces who deliver care, from our Board of Directors through all our teams across five portfolios; we believe they are all essential to creating what the MOHLTC discussion paper describes as a “better connected, more integrated patient-centred health system – one that responds to local needs and is committed to continuous quality improvement.”

Sincerely,

Caroline Brereton, CEO  
Dieter Pagani, Chair  
Mississauga Halton CCAC  
Board of Directors
The Faces of Patients

Our patients are our neighbours, our family members and our colleagues. They are 1 in 26 of all residents living in the Mississauga Halton region. They are children with medically complex care needs; adults recovering from surgeries and treatments; seniors hoping to remain at home with some independence; and people with life-limiting illnesses.

We are proud to care for each of our 47,000 patients and respond to 115,000 calls for help to our contact centre, seven days a week, 365 days a year.

Our patients are people like:

- Alan Fryer and his devoted wife, Barbara
- Dave Williams and his tireless fight to survive
- Sharon McMaster McKeown and her feline companion
- Krish Verma and his loving parents, Gauri and Amit
- St. John Blakeley in need of wound care
- Jason Lowry and his loving mother, Jeannie

This organizational overview presents the teams and people who care for and support all patients in the Mississauga Halton region, including the individuals featured. While patients and families will be the beneficiaries of proposed changes in Ontario’s health system, they also rely on our organization to ensure they continue to receive excellent care and are not put at risk.
<table>
<thead>
<tr>
<th>Portfolio</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care Portfolio</strong></td>
<td></td>
</tr>
<tr>
<td>Access Care Team</td>
<td>5</td>
</tr>
<tr>
<td>Hospital Team</td>
<td>6</td>
</tr>
<tr>
<td>Community Team</td>
<td>7</td>
</tr>
<tr>
<td>Placement Team</td>
<td>8</td>
</tr>
<tr>
<td>Children’s Health Services Team</td>
<td>9</td>
</tr>
<tr>
<td>Short Stay and Central Ordering Team</td>
<td>10</td>
</tr>
<tr>
<td>Provider Relationships and Programming Team</td>
<td>11</td>
</tr>
<tr>
<td><strong>Regional Programs and Strategic Development Portfolio</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care Integration Team</td>
<td>12</td>
</tr>
<tr>
<td>Palliative Care Team</td>
<td>13</td>
</tr>
<tr>
<td>Health Link Secretariat Team</td>
<td>14</td>
</tr>
<tr>
<td>South West and North West Mississauga Health Links Team</td>
<td>15</td>
</tr>
<tr>
<td>Strategy and Collective Impact Team</td>
<td>16</td>
</tr>
<tr>
<td><strong>Corporate Services Portfolio</strong></td>
<td></td>
</tr>
<tr>
<td>Finance Team</td>
<td>18</td>
</tr>
<tr>
<td>Provider Relations, Performance and Procurement Team</td>
<td>19</td>
</tr>
<tr>
<td>Information Management and Technology Team</td>
<td>20</td>
</tr>
<tr>
<td>Facilities Team</td>
<td>21</td>
</tr>
<tr>
<td><strong>People and Quality Portfolio</strong></td>
<td></td>
</tr>
<tr>
<td>The Learning and Organizational Development Team</td>
<td>22</td>
</tr>
<tr>
<td>Human Resources Team</td>
<td>23</td>
</tr>
<tr>
<td>Quality and Outcomes Team</td>
<td>24</td>
</tr>
<tr>
<td><strong>Executive Office Portfolio</strong></td>
<td></td>
</tr>
<tr>
<td>Strategic Communications and Partnership Advancement Team</td>
<td>26</td>
</tr>
<tr>
<td>Ombudsperson, Privacy Officer and Ethics Team</td>
<td>27</td>
</tr>
<tr>
<td>Executive Office Team</td>
<td>28</td>
</tr>
<tr>
<td><strong>Executive Team</strong></td>
<td>29</td>
</tr>
<tr>
<td><strong>Mississauga Halton CCAC Board of Directors</strong></td>
<td>30</td>
</tr>
</tbody>
</table>
The team

The Access Care Team (contact centre) includes 94 regulated health professionals, team assistants and information and referral experts who work from 8:30am to 9:00pm, seven days a week, 365 days/year to respond to people’s calls for help and information. The team responds to 115,000 calls annually or one every two minutes. The team works closely with Community care coordinators to provide support to all patients during weekends, holidays and evenings, so patients have help when they need it.

No referral is ever needed for a person to call the Access Care Team. Team members are also the first professionals to speak with a person who is referred by a physician or other health care provider, leaves hospital or contacts us directly for help; the only exception are patients with complex care needs who receive support from our hospital-based care coordinators, providing patients with the intensive level of care required to return home safety.

The team of experienced nurses, rehabilitation therapists and social workers, including some with long-term care and other specialized expertise, apply their clinical knowledge to arrange care that best supports each patient’s needs. They are the ‘human Google’ to answer people’s questions about Ontario’s health care system. The team also helps people find a family doctor.

The team also helps patients go home from hospitals outside our region, including Princess Margaret, St. Michael’s and SickKids, as well as those from local hospitals, who don’t have complex care needs.

The team sources and posts information on Mississauga Halton Healthline about neighbourhood resources available to people living in the region.

The evidence

In 2015, the team helped 30,963 patients receive care coordination and health services.

The team responded to 115,000 calls and met high standards in 2014/15, specifically:

• For 96 per cent of all calls, the team coordinated care for patients leaving hospital and contacted them within 24 hours of the first call
• For 100 per cent of all calls, the team coordinated care for patients living in the community and contacted them within 72 hours of the first call
• For 92 per cent of all calls, a team member answered the call before it went to an answering machine.

That is how the **Access Care** team delivers care to 47,000 patients.
Hospital Team

The team

The team of 103 care coordinators and valued team assistants are located in six hospital sites across the region and are available seven days a week for patients and families. Care coordinators meet with patients with complex care needs in hospital and make the important human connection with patients leaving hospital; they speak with family members and caregivers, assess and coordinate their patients’ care needs to return home safely. Team assistants are often the first face of our organization, working with hospital staff, patients and families to ensure the delivery of high quality care.

As regulated health professionals, Hospital care coordinators give patients confidence to leave hospital and return home safely. They are strong advocates for patients, working with hospital staff and physicians. They are closely connected with their Community team colleagues and are the link for patients to move from hospital to home. This is supported by our patients’ electronic patient record which provides easy access to information that is essential for effective discharges from the hospital.

Our Wait at Home begins in the hospital and enables patients to receive care at home while they make decisions about moving to long-term care. This enables patients with complex care needs to receive care at home while they make decisions about moving to a long-term care home.

The team also has care coordinators located in hospitals’ emergency department (ED) and the urgent care centre (UCC). Working with the ED and UCC hospital teams, they intervene to help people, particularly the frail and elderly, avoid being admitted to hospital and to help them avoid visiting EDs in the future. These are vital human connections and the team is located where patients most often feel in crisis.

The evidence

- 60 per cent of all patient referrals to our organization come from hospitals
- 16,342 patients were assessed for care in the region’s six hospital sites to enable safe discharge from hospital to home
- 96.2 per cent of patients received nursing care within five days
- 92 per cent of patients with complex care needs received care from personal support workers within five days
- The team started 422 long-term care home applications with patients in hospital
- Care coordinators in hospital emergency departments and an urgent care centre connected with 6,013 patients to help them avoid hospital visits

Helping Zhen home with a care plan that meets his needs in the community

A care coordinator met with Zhen in hospital after his bowel obstruction surgery. Zhen did not speak English and lived in a group home. Due to frequent visits to hospital, it was assumed that long-term care was the safest place for Zhen. When meeting with him to plan his move from hospital to home, his care coordinator recognized the concerns for Zhen’s clinical stability but learned he wanted to go home. She participated in a care conference, meeting with hospital staff and Zhen’s physicians, advocating for his return to the group home with nursing care to manage his recuperation. She brought in an interpreter to assist Zhen. He was able to return to his group home safely.

That is how the Hospital team delivers care to 47,000 patients.
Community Team

The team

The 119-person Community team includes care coordinators with health care backgrounds in nursing, physiotherapy/occupational therapy and social work, as well as valued team assistants and rapid response nurses. Patients contact our CCAC directly; no referral is needed. Patients are also referred to us by hospital staff, community partners, physicians or family.

The team assesses each patient’s health care needs, goals and concerns. Early discussions focus on identifying what patients want to achieve. The care coordinator applies clinical judgment to develop a coordinated care plan to help patients reach their goals and remain in their homes for as long as possible.

Care may include specialized nursing for wound care, rehabilitation or rapid response nursing. Rapid response nurses provide the most vulnerable patients with intensive care for the first 30 days after they leave hospital, when they are at greatest risk of returning to hospital. To learn more, watch this video.

Care coordinators may also refer patients to other community services, such as adult day programs to provide social and mental stimulation in a safe environment, often watching the adult day program video features together.

Community care coordinators monitor patients’ progress and update care plans as their patients’ health needs change, maintaining an open dialogue to keep the patient and their family informed about the care. When other options are exhausted, care coordinators also guide patients and families through the emotional journey to long-term care, answering questions and sharing information and resources, such as long-term care videos and our wait list.

To learn more about the excellent care provided by our Community care coordinators, watch the stories of patients Sharon, Dave, and Alan as they survive, thrive and cope to find a ‘new normal.’

The evidence

The Community team cared for 14,655 patients in 2014/15 and continue to provide care coordination and support for an average length of 281 days for patients with chronic care needs and 126 days for patients with complex care needs.

From April 1, 2015 to January 1, 2016, Community care coordinators held 53,500 face-to-face patient visits or phone calls to support, monitor and adjust their patients’ care based on their evolving needs.

The team’s rapid response nurses supported 1,018 patients and intervened to keep patients safe at home and out of hospital.

As a result of our care coordinators, we have one of the lowest hospital readmission rates in Ontario at 15.5 per cent.

Relentless pursuit of quality care for younger patient

Andrea was a 32-year old woman living alone in subsidized housing who had several physical and mental disabilities, including speech challenges. When a mental health community health agency person found Andrea in a cockroach-infested apartment and unable to safely care for herself, they contacted us for help.

Our care coordinator spent extensive time to help Andrea, learning about her background and researching options that would give her the best quality of life. Sadly, she learned Andrea was sexually abused and this experience made it impossible for her to live in a group home. After exploring alternatives, Andrea’s care coordinator determined the safest place for her was in long-term care. The Community team went into research overdrive to locate and eventually move Andrea to a long-term care home with younger residents, closer to Andrea’s age.

Several weeks after her move, Andrea called and left her care coordinator a heartfelt voice message: “Thank you,” she said.
Placement Team

The team

The 24-member Placement team includes placement coordinators, care coordinators and team assistants. They support patients, along with their caregivers and families, through all aspects of the complicated long-term care application process.

Serving as advocates and advisors for patients and families, the team helps find the best place for each patient to safely enjoy each day, recover or live for the long term.

The team arranges short term rehabilitation and monitors the progress of patients who may need to recover from an illness or operation, also known as convalescent care. When carers require a much needed rest to rebuild their emotional and physical strength to continue caring for their loved one, the team can offer suggestions around respite and Adult Day Programs.

In some cases, the team supports patients with accessing special behavioural support units where individuals with unpredictable behaviours may benefit from detailed care planning and intervention.

The team supports patients and families from outside Ontario who need long-term care in the region and helps residents who want to move to a different long-term care home.

The team collaborates with psycho-geriatrician resource consultants, hospital discharge planners and our organization’s Privacy and Ethics team and supports patients through consent and capacity board hearings. Together, they identify solutions to help patients with complex scenarios and placement challenges.

The team manages the wait list for the 27 Mississauga Halton long-term care homes and educates the public on the range of care services available.

The evidence

The team supported 3,160 patients and their families to apply for long-term care in 2014/15.

- The team referred 649 patients to adult day programs
- They made it possible for 370 patients to receive convalescent care
- 158 patients entered short-term ‘respite’ to help loved ones rebuild their strength to continue caring

That is how the Placement team delivers care to 47,000 patients.

Placing patients in care that gives them the best quality of life

Helping patients move into long-term care is a time-sensitive process where, often, families are making difficult emotional decisions for their loved ones. While long-term care is appropriate for some patients, it’s not always the best solution.

William is a patient who lived alone with limited family support; he was well known in Georgetown by Police Services sometimes displaying resistive and combative behaviours as he walked aimlessly, wandering outside during the day and night, regardless of the weather.

When the Placement team first met William’s family, they were adamant that moving him to long-term care was the only option; they couldn’t see that long-term care would not prevent William from wandering.

The team met with the family, local police, the Halton Geriatric Mental Health and Outreach team, the Alzheimer’s Society and the long-term care partner to explain options; the family better understood the risks to William and were receptive to alternatives. With the family’s support, William moved to a special behavioural unit in Hamilton, until a suitable long-term care home could be found in Georgetown. The Placement team ensured William remained safe and did not wander.
Children’s Health Services Team

The team

The Children’s Health Services team of 27 members includes care coordinators, mental health and addiction nurses and a paediatric rapid response nurse; all are registered health professionals. The team also includes valued team assistants.

The team provides care for newborn to 18-year-old patients in four main areas: children’s health services, school health support services, mental health and addictions and paediatric rapid response nursing.

Care coordinators meet with children and their families to assess their needs and discover their personal goals. The care coordinator applies clinical judgment with knowledge of community resources, cultural accommodations and funding options to develop a care plan to meet their young patient’s needs. Learn more by watching Krish’s story.

The team added a rapid response paediatric nurse to help parents care for an infant or young child with multiple medical conditions. She educates parents to use equipment, undertake procedures, administer medications and watch for side effects.

School health support services

The team provides nursing, rehabilitation, speech language, social work and nutrition services to help children participate in public, private or home schooling. Care coordinators collaborate with therapists, school staff and the student’s family to assess their patient’s needs and develop the care plan. The team also works with educators and therapists to integrate assistive technology or to modify the classroom’s lighting or sound to counter children’s medical challenges.

Mental health and addictions nurses

Our mental health and addictions nurses identify, assess, counsel and stabilize adolescents struggling with mental health and addiction challenges.

Our nurses draw on their clinical expertise, including knowledge of medications, side effects, interventions and community resources, to assess needs and develop a trusted relationship with students. Recognizing mental health and addiction challenges don’t stop at the end of a school day, counselling is complemented with therapy and support in the community. Learn how a team member saved the life of Stacey, a student suffering from depression.

The evidence

The team delivered care to 4,941 children and teens in 2014/15:

- Care coordination and comprehensive care planning to support children and teens living at home
- Occupational therapy to 1,428 students at school
- Physiotherapy to 497 students at school
- Speech therapy to 1,024 students at school
- Care for 91 students with multiple medical conditions or disabilities so they can attend school

The team’s rapid response paediatric nurse care for 29 patients since September 2015, providing critical interventions to help parents provide care to their children.

Caring for a family in crisis

Our care coordinator was providing extensive care for two siblings who shared a debilitating genetic defect. Shortly after, a third child was born with a heart disorder; then, tragically, the oldest child passed away. And then the father developed multiple sclerosis.

Stress took its toll on the father’s health and his systems started to break down. Trying to care for everyone also pushed his wife to a near crisis.

The children’s care coordinator arranged for a Community care coordinator to support the father. Working in the best interests of the whole family, they pooled existing resources and identified Ontario Disability Benefits and other services available. With family-centred care in place, the father’s health improved and the mother could once again manage the day-to-day care of her family.

That is how the Children’s Health Services team delivers care to 47,000 patients.
Short Stay and Central Ordering Teams

The Short Stay team

The 26-member Short Stay team coordinates short-term acute and rehabilitation care for patients following surgery, illness or hospitalization.

The team coordinates medical services, educates patients about their conditions and helps patients access community resources. Our care coordinators telephone patients when they return home from hospital or after injury or illness, assesses their specific needs and develops a care plan – all quickly and virtually.

Our care coordinators arrange for a nurse in a clinic or at home to provide wound care, for example to manage a drain inserted in a wound after abdominal or hip surgery. The team also coordinates rehabilitation care to help patients return to independence. Three care coordinators specialize in caring for patients with cancer to help them recover after surgery or chemotherapy or radiation treatments.

If those patients need longer-term care, the team engages a Community care coordinator to support patients’ longer-term needs.

Central Ordering team

The Central Ordering team of seven team assistants serves as the single point of contact for ordering all equipment and supplies for all care coordinators from Children’s, Short Stay, Hospital, Community and Palliative care teams, as well as contracted service providers, to support patients.

Using the patient’s electronic patient record, the team reviews each order and applies their clinical judgment to prioritize urgent orders, such as pain medications for cancer treatments.

The evidence

- 14,796 patients were supported by the Short Stay team in 2014/2015
- The Central Ordering team processes 150 to 200 orders daily; 90 per cent of those orders are processed accurately and on time

That is how the Short Stay and Central Ordering team delivers care to 47,000 patients.

Helping a patient ‘get their life back’

Christina was an active 43-year-old with a demanding career when an abdominal issue sent her to hospital. She needed a catheter inserted and after her release from hospital, Christina was referred to our Short Stay team to help her recover.

Christina was desperate to return to work as quickly as possible. Her care coordinator understood how returning to her workplace could improve Christina’s psychological and physical well-being. However, based on experience, she knew to balance Christina’s desire to return to work with her recovery needs.

The care coordinator learned that Christina’s office was close to one of our nursing clinics. She coordinated Christina’s care in the clinic nearer her work but outside her home area so Christina could return to work part-time; during her lunch hour, she went to the clinic for her care. Christina recovered in 42 days.

Prioritizing medical supplies for the best outcomes

When 82-year-old Yasmin was released from hospital after knee surgery, she was referred to our Short Stay care coordinator. Unfortunately, surgery combined with lying in a hospital bed exacerbated Yasmin’s diabetes and left her with painful pressure ulcers on her tailbone, along with the post-surgery wound.

After assessing Yasmin’s needs, her care coordinator developed a care plan for her. Yasmin’s treatment required numerous supplies, including general wound care materials, as well as specialized gel pads to treat her pressure ulcers. Given Yasmin's pressure wounds, diabetes and other chronic conditions, the Central Ordering team prioritized her order to ensure supplies were in place for Yasmin to begin treatment immediately to ease her pain.
Provider Relationships and Programming Team

The team

The six people on the Provider Relationships and Programming team are health professionals who oversee patient care in four specialized areas: rehabilitation, wound care, integrated care and professional practice expertise that designs and delivers enhanced care coordination.

For each specialized area, the team researches and implements best practices, develops and delivers training to achieve optimal patient outcomes.

The team’s rehabilitation programs enable patients to leave hospital sooner, recover at home and remain at home. They help patients improve, maintain or regain their physical strength, movement and quality of life after surgery, an illness or accident. The team works with physiotherapists, occupational therapists, dieticians, speech pathologists and social workers to develop a rehab program tailored to each patient’s multiple needs.

The team’s wound care programs incorporate the most current evidence-based treatments to help patients heal faster. They ensure the level of wound care delivered in hospital is maintained after patients go home by collaborating with physicians, nurses, physiotherapists, dieticians, and clinicians in wound care clinics.

The integrated care program focuses on improving the quality of life for patients with chronic health illnesses and unpredictable care needs at home and in the community by ensuring that the appropriate care is maintained to promote a degree of stability, encourage self-care, and reduce avoidable hospital use. The team facilitates regional integration by improving communication and collaboration with regional partners on program development that proactively identifies risks associated with falls and medication management. In doing so, the patient and family move through their care journey seamlessly and with an understanding of what to do to minimize their risks and how to access community resources to keep safe at home.

All these programs are supported by a Project Manager who helps identify and coordinate the different steps necessary for their delivery.

Professional practice collaborates with our Quality and Risk team to support safe patient care by reviewing patient safety events and recommending practice changes that support improvements in the delivery of patient care. In addition, professional practice supports the application of leading, and evidence-based practices in the development of core competencies that each care coordinator consistently uses to effectively set goals with patients and interact with other health care professionals and community resources.

The evidence

The rehabilitation program supports 4,400 patients annually; patients spend 6.2 months on average in rehabilitation. For example, patients who suffered a stroke are able to achieve greater independence after rehabilitation.

The wound care program supports 28,764 patients annually; for wounds that can medically heal, 75 per cent of healing goals were met within 50 days, less than half of the overall length of stay if the wound care program did not exist.

For professional practice, 87 care coordinators - 1/3 of all our care coordinators – completed special training and now apply the core competencies required for enhanced care of patients.

That is how the Provider Relationships and Programming team delivers care to 47,000 patients.
Primary Care Integration Team

The team

In partnership with the Mississauga Halton LHIN, the Primary Care Integration team introduced a new role of primary care advisor to support primary care providers - a role unique in Ontario.

The five-member team is responsible for establishing ongoing, productive relationships with primary care providers in the seven Health Link regions across the Mississauga Halton area. Primary care advisors are divided among those regions, developing a trusted rapport with primary care providers, including family doctors, physician assistants, nurse practitioners and other health professionals working with family health teams.

The team builds the vital connections between and among primary care providers and the breadth of services and community resources that benefit patients, including but not exclusively limited to our care coordinators.

To support primary care integration, the team keeps primary care providers informed about health care resources and social services available in their region and gathers feedback from primary care providers on how the health care system can better support them in caring for patients. In partnership with the Primary Care Network and our LHIN, the team developed a primary care database and DocSearch, an e-compendium to help doctors know which specialists are in their region and available to see patients. Also, primary care advisors provide timely information on rapid response nursing, mental health resources and electronic referrals for patients living with diabetes. Having primary care advisors as the central point of information for primary care providers eliminates duplication and is more efficient for primary care providers. The team shares feedback from primary care providers with community services agencies, the Mississauga Halton LHIN and our care coordinators, all to better support patients in the community.

The evidence

Primary care advisors:

• Achieved 700 direct primary care engagements with physicians, across 926 unique practices; this represents meaningful engagements with 76 per cent of all primary care providers in the Mississauga Halton region
• Engaged 100 per cent of primary care practices, gathering information, trends and feedback on key regional issues
• For example, when talking with primary care advisors, physicians raised concerns for mental health and addiction issues of their patients 22 per cent of the time, providing valuable feedback to the Mississauga Halton LHIN of the need for increased awareness of mental health resources and support.

That is how the Primary Care Integration team delivers care to 47,000 patients.
Palliative Care Team

The team

The Palliative Care team of 25 people includes one director, 14 care coordinators, five nurse practitioners (NPs), five valued team assistants and one administrative assistant. All clinical members of the team are trained and experienced in palliative and end-of-life care and possess a wealth of knowledge about palliative community resources available in neighbourhoods across the region.

From that first visit, care coordinators meet patients and their caregivers and develop a personalized care plan together, based on the patient’s goals and clinical care needs. They initiate advanced care planning conversations with patients and loved ones so everyone understands and respects the patient’s wishes.

For patients in the last 30 days of their life journey, the team coordinates the more intensive enhanced end-of-life care needed by patients at that time. The team wraps services around a patient during this time and supports them to remain in their home and community, and assist them to die in their place of choice, whether that is home, hospice or hospital.

The evidence

The team cared for 2,010 patients with palliative care needs in 2014/15, a 3.2 per cent increase from 2013/14, coordinating 330,640 care visits – an increase of 8.7 per cent.

That is how the Palliative Care team delivers care to 47,000 patients.

Caring for Jason and Anita and their families at the end of life

For many patients with palliative care needs, care coordination starts with a diagnosis of a life-limiting illness. Watch Jason’s story and learn how his care coordinator was the lifeline for him and his beloved mother for the last eight months of Jason’s life.

Anita’s needs were more immediate. Anita was referred to the Palliative team as she was leaving the hospital. She made her wishes clear: she did not want to die in hospital; she wanted to die at home surrounded by everything she loved most – her family and her home with pictures of her kids and grandchildren. Anita wanted her last days at home with them.

The team arranged for transportation immediately to take Anita home. They coordinated essential equipment and supplies quickly for Anita’s care. Her Palliative care coordinator arrived at Anita’s home shortly after she reached home to support her immediate needs.

Her Palliative care coordinator reviewed her medical needs and provided the necessary nursing and personal support for Anita and organized symptom management kits with the appropriate medication to manage Anita’s pain. With her family beside her, recalling special memories and laughing about the shenanigans over the years, Anita died 48 hours later, as she wished.

The team provides palliative care coordination for patients, age 18 and older, in their last 12 months of life and enhanced end-of-life care in the final 30 days of life. Our eldest patient receiving palliative care is 102 years old. The team is highly inter-connected with care coordinators from the Community, Hospital and Health Link teams and physicians who refer patients, along with requests for palliative care from patients and family members. Once a patient has a palliative care coordinator, they receive a call within 24-48 hours and a home visit within three to seven days days to assess the patient’s needs.
Health Link Secretariat Team

The team

The three members of the Health Link Secretariat team support all seven Health Links in the Mississauga Halton region. For a view of all Health Links, click to this map. The Secretariat is a regional resource that understands the unique nature and challenges of each Health Link; facilitates collaboration and standardized processes to ensure consistency; facilitates continuous process improvement through the promotion of shared learning and best practices; drives communications to promote and champion each of the Health Links; helps the Health Links identify and support patients with the most complex care needs and high users of the system to achieve their individual and collective goals. For more information, watch this Health Link Secretariat video.

That is how the Health Link Secretariat team delivers care to 47,000 patients.

Health Link will support a particular patient. Hospitals, primary care providers, community agencies and other partners can refer patients to Health Links through the central access; the referral will be directed to the Health Link region in which the patient resides. The team is working on developing an e-referral process for Health Link patients.

The team developed a common care pathway, which was implemented across all seven Health Links for patients to receive coordinated care plans focused on achieving their personal goals. Each patient’s health care provider will participate in a care conference to review his/her patient’s progress and plan ongoing treatment.

The evidence

The team facilitated:

- Standard eligibility criteria to identify the top five per cent of patients with complex care needs in the Mississauga Halton region who would benefit from Health Links
- Standard referral form for all seven Health Links in the Mississauga Halton region
- Standard referral process for all seven Health Links, while considering their unique nuances
- Regional communications strategy to ensure consistent messaging and stakeholder engagement
- Regional indicator list with standard data definitions to drive performance management
- Project management working group to identify and address problem areas, share best practices and lessons learned and provide a platform for Health Link operations to be discussed

One-call access to coordinate care closest to Nala’s home

It was Sunday on a long weekend when Nala, a 66-year-old woman, arrived at the hospital emergency (ED) department for the third time in a month. It appeared that Nala had not used her walker again and had stumbled; but she couldn’t remember details. Nala takes several medications for sleeping and pain management. Her symptoms suggested she might not be taking the right pills, in the right amount, at the right time.

The ED was packed. The doctor who examined Nala called the East Mississauga Health Link, even though Nala lived in Milton. With central access, it only took one call for the doctor to refer Nala for care. The doctor trusted his referral would be routed to the Milton Health Link in the patient’s neighbourhood. Now Nala is receiving care that supports all her needs. Nala has not been back to hospital since she became a Health Link patient three months earlier.
South West and North West Mississauga Health Links Team

The team

The South West and North West Mississauga Health Links team includes four core members who support the South West Mississauga Health Link, led by our organization, and the North West Mississauga Health Link, co-led by Nucleus Independent Living and Credit Valley Family Health Team.

The team provides leadership to a collaboration of community organizations, primary care providers, care coordinators and others who work together to improve the health outcomes of the most vulnerable patients by wrapping them in a coordinated, multi-disciplinary team, including patients’ family members and caregivers. Our Community care coordinators are those patients’ main contacts, serving as a ‘lifeline’ by coordinating care provided by nurses, social workers, rehabilitation therapists, hospital staff and primary care providers; the team extends each patient’s circle of care beyond clinical care to include neighbourhood resources, such as community pharmacists, faith-based groups, mental health services, food bank supports and transportation services when necessary.

Our Health Links and care coordinators develop a coordinated care plan, based on patients’ goals, helping patients like Lawrence stay safe at home. Our care coordinator develops a coordinated care plan for each patient.

The team engaged more than 240 individual family doctors and family health team (FHT) primary care providers to refer their most vulnerable patients and to take an active role in their patients’ circles of care. The result was immediate; 66 per cent of South West and North West Mississauga Health Links patients were referred by those physicians. Eleven of those family doctors collaborate with care coordinators and participate in their patients’ circles of care.

The evidence

Since opening in November 2015, the South West and North West Mississauga Health Links have:

- Enrolled 79 patients with multiple health needs and developed 59 coordinated care plans
- Based on data collected for 33 patients, emergency department visits were reduced by 55 per cent
- Engaged family physicians to contribute to 86 per cent of coordinated care plans

That is how the South West and North West Health Links team delivers care to 47,000 patients.

Helping Darrell helps Dorothy and reduces unnecessary hospital visits

Dorothy, a cancer survivor with diabetes and a broken spine, is an amazing 75-year-old woman who takes care of herself. Her challenge was caring for her beloved, but cantankerous, 81-year-old husband, Darrell, who suffers from osteoarthritis, obesity, memory loss and mental health issues, as well as diabetes. Dorothy tired easily and every time she tried to help Darrell, he lashed out at her. His moods changed from content to sad to angry multiple times a day and he began to fall. After his fourth visit to the emergency department in one month, the hospital referred him to South West Mississauga Health Link.

Our care coordinator met with Dorothy and Darrell and quickly formed a circle of care team, which included Darrell’s family doctor, a personal support worker to help him manage his daily personal care, a physiotherapist for fall prevention training and to improve his mobility; Darrell was also enrolled in a mental health program to help manage his mood swings. For Dorothy, the care coordinator arranged for Darrell to have short-term stays in a nearby long-term care home to give her a break to gather her strength to continue caring for Darrell and herself.

Within two months, Darrell was in less pain, his outbursts decreased, his walking improved and falls declined. On several occasions Darrell called his care coordinator late at night for help, instead of rushing to the hospital’s emergency department. Dorothy’s health also improved, growing stronger with the Health Link’s support.
Strategy and Collective Impact Team

The team

The four-person Strategy and Collective Impact team plans and manages key strategies and operational priorities to advance continuous quality improvement for patients. If a strategic plan is the blueprint of better care for patients, the team ensures we deliver on that promise. The team manages change and applies oversight to assess our organization’s performance and report to the public.

We launched a new Strategic Plan in 2015; it’s our blueprint for improving care for people across the region. The team helps everyone across our organization focus on the vital work that is most meaningful to patients.

The team builds and sustains collaborative partnerships; it’s developing a patient and family engagement strategy, while overseeing research and grants to improve how we care for patients.

The team partners will all portfolios to develop our governance Balanced Scorecard to measure our organization’s performance for patient experience and outcomes and reports our results. Those metrics determine how effectively each project is meeting quality improvement targets; that work directly benefits patients and their families in how they experience care; and it ensures promises made for better care are achieved for all residents.

The evidence

The Balanced Scorecard reflects our focus on public accountability and transparency. The Balanced Scorecard is everyone’s responsibility in our organization. The team develops and tracks long and short-term goals and reports to residents and all Ontarians on the quality of care patients receive. For example, in 2014/15, 96.2 per cent of patients received nursing care within five days. And 92 per cent of patients with complex care needs received personal support within five days. This means that patients in this region received care faster than the provincial target, creating better experiences and outcomes for patients.

That is how the Strategy & Collective Impact team delivers care to 47,000 patients.

Focusing on what matters most to patients

Leading the management of our organization’s Strategic Plan, the team ensures a constant focus to achieve the key priorities that have the greatest impact on patients and families.

For example, our Care Coordination Program of Work is changing how patients receive care. The Strategy and Collective Impact team helps everyone in the organization focus on this priority for patients. Enhanced training enables care coordinators to quickly establish trusted relationships with patients; to consistently set health goals together based on what matters most to patients; to bring together care coordinators, health and neighbourhood resources to give patients what they need to recover at home, remain at home or die at home; it uses technology to share electronic patient records with other health professionals to reduce errors and repetition; it ensures only one-to-two contracted service providers visit a patient’s home. That is quality care and it requires the team to ensure we deliver that enhanced model of care.
Finance Team

The team

The 12-person Finance team performs the forecasting, financial planning, budgeting, reporting and accounting needed to support all operations that contribute to caring for patients. The team collaborates with multiple organizations, from contracted service providers to the Ministry of Health and Long-Term Care (MOHLTC).

Success in delivering care to patients requires creative, systems-level thinking. The Finance team uses its expertise to make effective decisions that optimize the financial resources of the organization and support patient care.

The team provides the financial analysis that shows how effectively care is delivered within a region for a specific group of patients. This information helps Patient Care managers identify where service is costing more to deliver, where service is more efficient, healing is faster or patient outcomes are better.

The team plans budgets to reflect our current patients’ needs and the community’s demands. They also ensure funding is available to meet the forecasted needs of a rapidly growing seniors’ population as identified in the region’s comprehensive Community Capacity Plan.

To help address fluctuating patient needs and improve accountability, the team often works behind the scenes to deliver value-added services to the Patient Care team. Care coordinators depend on the team’s weekly reports for the information they need to make informed decisions and allocate constrained care resources to patients in greatest need.

The evidence

The Finance team processes 18,627 invoices and transactions through 80 functional centres accurately and transparently. The team also manages payroll for 530 staff. One of the team’s top priorities is to ensure funding is available for 2.5-million care visits. This means they often need to turn on a dime to fulfill ad hoc requests to enable patient care or prevent a service interruption.

Payroll has implemented rigorous new internal audits to ensure compliance with Canada Revenue Agency legislation and employment standards. In support of the organization’s 12 hour shift pilot, significant work was required to ensure that the extended hours and payroll implications were aligned with the collective agreement.

That is how the Finance team delivers care to 47,000 patients.

Turning on a dime to flow funds

Personal support is often the most intimate and important to the quality of patients’ experiences; personal support workers are often the most consistent person in a patient’s home. When the Ministry of Health and Long-Term Care (MOHLTC) announced the personal support service (PSS) staff’s wage enhancement, the Finance team worked quickly with contracted service providers to ensure there was no disruption in care. This was much more complicated as our organization contracts with third-party providers to deliver all personal support that the care coordinators organize for each patient. The Finance team met the ministry’s extremely tight timeline, with the funding allocated without error. In fact, the team ensured we were among the top three CCACs to achieve 100 per cent compliance for personal support wage enhancement, ensuring no disruption in care to patients.
Provider Relations Performance and Procurement Team

The team

The five member team develops and monitors the full scope of services of 17 contracted service providers and three medical supply and equipment vendors for quality care delivery, patient satisfaction and improved processes to enhance quality improvement. The team is inter-connected with Hospital, Community and Palliative care teams. They foster productive and collaborative relationships with contracted service providers who deliver nursing, personal support and rehabilitation (physiotherapy, occupational therapy, speech language pathology, nutrition and social work).

The team measures several quality key indicators, as well as patient satisfaction with service providers via our Client and Caregiver Experience Evaluation (CCEE) conducted by a third-party researcher that measures three key indicators: timing of visits, overall satisfaction with the service and continuity of care.

The team manages the performance of five nursing clinics that provide care to all patients (except intravenous (IV) therapy for children under 12) and also ensures continuity between patient in-home and in-clinic care.

The team also procures and manages vendors to deliver essential medical supplies and equipment that are part of the care coordinators’ care plan and ordered by the Central Ordering team.

With the new enhanced care coordination practice, the team collaborated with service providers to align care with neighbourhoods, enabling patients to have fewer service providers delivering care by July 2016. Exercising flexibility in the contracts, the team is reducing the risk of errors and missed visits, and delivering a better patient experience by building relationships with smaller teams of nurses, therapists and personal support workers.

The evidence

Patients received nursing care from one of our five nursing clinics that has, on average, 50 appointments daily.

The team manages the delivery of 2.5 million visits, with 99.89 per cent provided as planned.

When evaluating the new clinical pathways for wound care, the team discovered that nursing clinics excelled at delivering quality care within a pre-set period of time, enabling patients to recover faster. The team then moved all nursing care for those types of wounds to clinics to deliver the best care for patients.

Contracting care that works for patients

Jake is suffering from late stage amyotrophic lateral sclerosis or ALS. He was hospitalized for respiratory failure; he chose to have a tracheostomy, knowing he would need a ventilator to breathe. Jake was adamant. He did not want to spend recovery time in the hospital; he wanted to be at home with his wife.

The team knew that no existing contracted service provider had the expertise to care for Jake who had just been released from the hospital’s intensive care unit (ICU). So the team sourced a specialized respiratory therapy company and structured a new vendor contract to provide care for Jake at home. Without that care, Jake could not safely leave hospital.

The team also worked with Jake’s Community care coordinator and existing service providers to integrate this specialized nursing into his care plan.

Jake went home with a tracheostomy supported by the new provider for the initial acute phase of his recovery; as he recovered, Jake’s care was seamlessly transitioned to his existing nursing providers.

The team helped Jake get home.

That is how the Provider Relations Performance and Procurement team delivers care to 47,000 patients.
The team

The Information Management and Technology (IM&T) team connects clinical staff to the evidence they need to make informed decisions to ensure the best patient outcomes. Its 24-member team includes four integrated departments that make this mandate possible.

Success starts with a dependable infrastructure. The team resolves 300-400 help desk requests a week, over 18,000 calls a year, to equip staff with reliable computers, mobile devices and other hardware to support patient care.

Staff use this infrastructure to run mission-critical applications that support patients at every touch point, from recording their information at first contact and assessment and monitoring for safety to sharing medical records with external health care providers. This team keeps those applications operating, up-to-date and scalable to anticipate patients’ demand for care.

The team deciphers health records to identify patterns that help care coordinators make evidence-based decisions about each patient’s care plan. They help implement upgrades and new releases to ensure the best available information is used to help patients. The electronic health record, called CHRIS, is part of the CCAC provincial record.

To advance quality health care for Ontarians, the team shares their expertise, providing decision-making support for the Community Quality Network, comprised of 26 community services agencies.

The evidence

The IM&T team meets specific service level agreement (SLAs) response and resolution times for three levels of need. The most critical SLAs ensure service interruptions that impact mission-critical applications are responded to within 20 minutes and resolved within two hours, 99 per cent of the time, 365 days a year, 12 hours/day.

The team supports improvements of CHRIS, by implementing a minimum of 2 upgrades each year. For example, the team makes it possible to reduce patient risk, while saving time, by electronically transferring vital patient information, such as blood type, allergies or heart conditions, from hospital into community care. Our hospital-based care coordinators enter a patient’s information once into CHRIS, which is updated with treatment details during their stay. This electronic record follows patients when they’re discharged to our community-based care coordinator.

Supporting daily care to improving patient outcomes

The IM&T teams’ four departments work in synchrony to help care coordinators manage their patients’ daily needs. Through the design and implementation of evidence-based, real-time dashboards called Insights, each care coordinator receives a customized summary of each patient. Like a hospital checklist, Insights is an efficient and effective tool that is essential to helping care coordinators ensure each patient receives timely contact, assessment and changes to improve their patients’ quality of life.

The team also delivers game-changer value when it uses existing data in ‘what if’ modelling to predict what will happen if a care program continues ‘as is’ and recommends course corrections that can significantly improve patient outcomes.

That is how the IM&T team delivers care to 47,000 patients.
Facilities Team

The team

The safety of patients and staff is the primary focus of the Facilities team of ten. The team secures, maintains, protects and supports the nine separate physical spaces our organization needs to operate, providing fire wardens, security after-hours, parking and off-site storage. They lease spaces; manage workspace allocations for all staff; coordinate occupational health and safety checks; conduct pandemic and emergency planning and business continuity; as well as maintaining security systems and insurance protection. When there’s a need to move people, renovate or expand space, the team coordinates logistics, liaises with health care partners and contractors, and manages workplace safety.

Beyond physical space, the team is also responsible for ordering, monitoring and maintaining all supplies, from stationery to essential medical forms. The team maintains 127 personal protection equipment (PPE) kits annually so staff can safely care for patients in hospital or at home without risk of infection.

The team has reception staff at two locations who welcome 144 patients and family members annually and arranges for them to meet with a care coordinator.

The team equips our direct care nurses with medical equipment, from thermometers to blood pressure cuffs, to support patient care in the community. It also prepares 5,916 comprehensive information packages annually for all patients, ranging from those who receive short-term care to those entering long term or palliative and end-of-life care.

The evidence

The team responds to over 579 maintenance or ergonomic-related requests annually from 530 staff who work from home or in one of the nine locations where we have care coordinators and team assistance providing care for patients.

The team manages three office leases, comprising 57,583-thousand square feet, negotiating the best rates to drive value for money.

Clearing the route for patients during the Pan Am Games

When the Pan Am Games in 2015 had six venues in Mississauga and surrounding areas, one venue in Milton held cycling time-trial races across a 20 kilometre square block area, which closed down access to patients’ homes for 2.5 days.

In close collaboration with the Hospital team, the Facilities team ensured the Pan Am races didn’t impact patient care. Together, the teams assessed the venue, determined detours around blocked areas and mapped out a two-kilometre radius to identify patients who might be affected. The teams ensured the time-trials did not prevent patients from receiving the care they needed. The team worked with care coordinators to pre-plan their patient visits during this event.

The team worked with contracted service providers who send nurses, rehabilitation therapists and personal support workers to patients in the affected areas, hosting information sessions and resolving related issues. They worked with two hospital corporations to ensure patients being discharged were safe.

By the close of the Pan Am Games, the team ensured that every patient received the care they needed and no one was at risk.

This is how the Facilities team delivers care to 47,000 patients.
The Learning and Organizational Development Team

The team

The team of nine focuses on three areas: learning, organizational effectiveness and change management.

The team includes five learning solution specialists who orient new and returning staff to the tools, people, programs and resources available so they can effectively manage their patients’ care. The team trains staff, in person and by online learning modules, to elevate employees’ knowledge in service of their roles to deliver care to patients. They also teach all new functions of the electronic health record to effectively manage patients’ care and facilitate integration with primary care and community agencies.

The team leads organizational effectiveness to continuously improve the performance of all employees to benefit patients: this includes coaching, performance management and evaluation, as well as employee recognition. The team helps employees support and learn from one another, while also celebrating and promoting excellence through formal annual Quality, Vision and Exceptional People Awards. They manage tuition reimbursement, enabling our organization to invest in employees and enhance their expertise in service to patients in the region.

All members of the team are certified to help build better teams through the Strength Development Index (SDI) methodology, a practical and effective tool for managing conflict and improving relationships, especially useful through change, integration and family dynamics.

Two members of the team are also certified executive coaches who help leaders effectively lead teams on behalf of residents across our region.

The team recognizes that enabling our people to be great through change enables great patient care. The team supports change management for all major projects. For example, for our enhanced Care Coordination Program of Work team members co-designed the training and joined care coordinators in patients’ homes to coach and validate the consistent application of enhanced core competencies. This includes enabling patients to identify their wishes, to obtain vital information needed for effective care, and to communicate that insight with a patient’s family doctor, community resources and clinical teams.

The evidence

Employee engagement survey results saw an increase of 26 per cent since 2014, validating a very engaged, committed team of professionals in service to patients and families.

• 78% of employees rate our organization as a great place to work, an increase of 21 per cent since 2013
• 100 per cent of leaders trained on the use of the Strength Deployment Inventory
• 40 per cent of leaders received formal coaching

That is how the Learning and Organizational Development team delivers care to 47,000 patients.
That is how the Human Resources team delivers care to 47,000 patients.
Quality and Outcomes Team

The team

The Quality and Outcomes team of six people develops and coordinates processes across the organization to monitor and manage risk, while improving quality and patient outcomes.

The team’s efforts centre on holding all teams accountable to high-quality standards and for mitigating risks to keep patients safe.

In 2014/15, the team recorded and reported on the 1,253 compliments, complaints and risk events that occurred in the process of caring for 47,000 patients annually. The team gathers information from each situation and consults all members of the patient’s extended circle of care, including service provider organizations, hospitals, community service agencies and retirement homes. Like hospital quality teams, their essential role is to learn exactly ‘what went wrong;’ recommending new processes and training or improving communication among health professionals. This is how patient safety is effectively improved and sustained.

The team develops the Quality Improvement Plan (QIP), published annually, focusing on key patient quality metrics and managing the quality improvement process for the organization. The team also develops and reports on the comprehensive enterprise risk map which identifies 14 risk categories and 51 potential risks to patients, staff and the organization.

The evidence

Seven per cent of all patients admitted to acute care hospitals in Canada suffer a medical misadventure. Ensuring safety and demonstrating quality improvement for care delivered in the home and community is an imperative for the Quality and Outcomes team.

The team conducts Advancing Patient Safety Sessions to determine root-causes and recommends actions for all adverse events, and shares the information with the Patient Care Quality Committee of the Board and the Board of Directors four-times per year.

That is how the Quality and Outcomes team delivers care to 47,000 patients.

1 Mortality Due to Medical Misadventures, Conference Board of Canada, 2016.
Strategic Communications and Partnership Advancement Team

The team

The Strategic Communications and Partnership Advancement team of 4.3 people, plus a communications summer intern, focuses on three areas: communications, stakeholder management and strategic board development.

Communications

The team helps people and patients by raising awareness about programs and services and the care we provide through community outreach, plain language print and video materials, and social media.

The team provides communications counsel, planning and delivery to advance strategic plan initiatives and key priority projects, focusing on information most vital for patients and partners. For example, the team created adult day program videos to help people select the right program for them or a loved one.

Stakeholder Engagement

Share Care Council: On behalf of David Fry, VP Patient Care, the team leads our patient and caregiver advisory forum, Share Care Council. This council of 15 volunteers from across the region meets each quarter, since 2014, to directly inform new programming and services. Visit Share Care Council for details.

Members of Provincial Parliament (MPPs): Our CEO, Caroline Brereton, meets regularly with all 10 MPPs across our region. She informs MPPs on programming changes, quality of care updates and advocates on behalf of patients.

Health Fair: An annual event that shares information among our care coordinators and 60 community agencies about the resources available to patients and families in neighbourhoods across the region. The event enhances care coordinators’ awareness of community health and social supports to enable better care for patients.

Strategic Board Development

The team supports the Governance Committee to proactively recruit candidates for the Mississauga Halton CCAC Board of Directors, based on skills needed to advance care for residents of the region; they also deliver orientation to all Board members. The team created and implements the multi-year education plan on behalf of the Governance Committee to support the high-performing Board of Directors.

The evidence

Your Health, Your Way community outreach: increased community awareness of our organization by more than 45 per cent, year-over-year, through public engagement and education sessions.

Public polling with independent third party: year-over-year, increased community residents’ perceived value of organization by 5-8 per cent or 65,000 people.

Social media:
- 2,000 Twitter followers
- 123,029 YouTube views of our videos that help patients and families understand and use their health system

Seamless Transitions: Hospital to Home: One team member earned three awards for her communications expertise.

Health Quality Ontario featured two programs, Seamless Transitions and Share Care Council in its Measuring Up yearly report.

Health Fair: number of community participants increased 34 per year.

That is how the Strategic Communications and Partnership Advancement team delivers care to 47,000 patients.

Ostomy booklets help patients find their ‘new normal’ life

Ostomy surgery is life changing; but for most people, it’s a second chance at life. Working with our wound care professional practice lead, as well as 12 hospital and community partners, the team developed an ostomy booklet to give patients the confidence to manage their care at home. The booklet provides practical information about living with ostomy, written in plain language; it’s intuitive to use and available online and in print to help create what patient Dave calls “anew normal.”

Whether leaving hospital, receiving care from our care coordinators or other community agencies, all ostomy patients receive the booklet. Patient feedback tells us, “This answers so many questions I didn’t have the nerve to ask.”

Ostomy booklets help patients find their ‘new normal’ life

That is how the Strategic Communications and Partnership Advancement team delivers care to 47,000 patients.
Ombudsperson, Privacy Officer and Ethics Team

The team

The 1.3 resources in the Ombudsperson, Privacy and Ethics team have a three-fold mandate to:

1. Resolve escalated complaints from patients or their caregivers/family members
2. Collaborate with and provide advice and guidance to teams in addressing ethical issues and dilemmas
3. Ensure the organization complies with privacy legislation

The team addresses patient complaints that are escalated beyond the care coordinator and managerial level. The team provides dispute resolution services at varying stages of the patient’s care to help ensure a satisfactory and fair outcome for patients and their loved ones.

Often, communication breakdown is at the root of satisfaction issues. The patient or their carer/family member may be upset because they want more or different care. The team uses specialized negotiation techniques to focus on the needs of each party and works to achieve the best solution for everyone. The team works to resolve complaints received from a variety of sources, including patients and caregivers, the constituency offices of Members of Provincial Parliament and the Long-Term Care ACTION Line.

The team also serves to coach, educate and uphold ethical practices and to protect each patient’s privacy during and after care delivery. Our care coordinators and contracted service providers apply an ethical framework to protect patients and to balance information and advice with patients’ wishes and right to make autonomous care decisions.

As the sector moves towards a province-wide electronic patient record, CCACs are enabled to share private patient information securely with hospital partners, contracted service providers, family doctors, and Health Link community partners who are part of a patient’s care. While giving multiple partners access to patient data reduces delays, errors, unnecessary duplication and improves outcomes for patients, it also demands rigorous privacy oversight.

The team uses a combination of established internal privacy audits, training and confidentiality agreements to safeguard each patient’s private information. The team audits and monitors for any potential breaches of privacy.

The evidence

Privacy breaches declined, from 41 breaches in 2013/14 to 34 in 2014/15. This success is due to the team’s efforts, combined with the organization’s shift toward using more secure electronic channels for patient data and away from less secure technologies, such as faxes.

Of the 47,000 patients the organization cares for annually, 156 complaints were escalated to the team in 2014/2015 for resolution. 99.3% of complaints to the Ombudsperson’s office were successfully resolved without an appeal to the Health Services Appeal and Review Board (HSARB).

Solving a grooming challenge to maintain a patient’s dignity

Jennifer, an African-Canadian patient who had a medical condition that made it difficult for her to style her own hair, wanted her personal support worker (PSW) to wash and braid her hair once a week because it was unruly to manage. Unfortunately, the PSW did not know how to braid the patient’s hair. While pleased with the other care we provided, this patient believed that by not braiding her hair, the PSW violated her human rights.

The team met with the patient and her care team. The patient described the complexity of her hair care needs and we confirmed it was only due to the lack of braiding skills by PSWs. The team resolved this complaint by working with Jennifer’s care coordinator and the Contracts team to find a PSW with the requisite braiding expertise. They arranged for this care provider to attend to the patient’s hair each week, and in doing so, restored her dignity and quality of life.

That is how the Ombudsperson, Privacy Officer and Ethics team delivers care to 47,000 patients.
The Executive Office Team

The Executive Office team assists the CEO in maintaining important relationships with patients, caregivers, community service agencies, contracted services providers, hospitals, physicians, and other important partners across the region in caring for patients in the interconnected health system, as well as staff.

The team assists the Mississauga Halton CCAC Board of Directors by facilitating strategic planning retreats, monthly meetings of the full Board and its Governance, Patient Care Quality and Audit and Resources committees, as well as the annual general meeting to enable our high-performing Board to effectively govern care of 47,000 patients and 115,000 people who call the Access Care Team seeking help.

The evidence

The team organizes the Board’s annual general meeting to help Board members to identify Committee chairs and develop their annual work plans in the summer period and referencing bylaws and policies. This helps Board members to roll up their sleeves and get down to work on behalf of residents across the region, focusing on what matters most to patients.

Assisting the MH LHIN includes supporting the joint Mississauga Halton LHIN and CCAC Joint Board Collaboration Committee since 2012, which began with the Community Capacity Plan, and continues today to identify governance implications of the structural changes proposed in the Ministry of Health and Long Term Care’s discussion paper, Patients First: A Proposal to Strengthen Patient-centred Health Care in Ontario.

That is how the CEO Executive Office team delivers care to 47,000 patients.
Executive Team

The team

Leadership is required to manage the 22 essential teams in the five portfolios of our organization profiled in the preceding sections of *The Faces of Care*.

The Executive team, headed by Chief Executive Officer Caroline Brereton, is the most senior management body, focused on delivery quality care to 47,000 patients. Supported by a team of valued executive assistants, the team champions collaborative relationships within teams throughout our organization, as well as with the LHIN, because working together to create an integrated system of care is better for patients.

In addition to overseeing the daily work of our multidisciplinary and interconnected teams, the Executive leadership’s key accountabilities include strategy, quality, culture, resource stewardship, operational excellence and regional integration.

Establishing good communications between our teams, patients, partners and care providers is critical to meaningful experiences and outcomes for patients. In our environment, relationships matter; the team values communications as a critical enabler in our relationships with patients and within our organization.

With the second fastest growing senior population in Canada, the team is agile to anticipate people’s needs and respond quickly to our constantly changing and complex environment. This is one reason for the creation of a Joint Collaboration Governance Committee of the Mississauga Halton CCAC and LHIN Boards of Directors in 2012 that oversaw development of an unprecedented, comprehensive Community Capacity Plan to forecast the needs of residents over the next 15 years.

The evidence

The team engages and listens to our patients and family caregivers directly through our 15-member patient and caregiver advisory forum, Share Care Council.

The team understands that measurement is also essential to quality care. Successful outcomes are based on understanding why some actions or processes worked well and why some did not, further informing continuous improvement.

The team monitors patient care and quality and safety through the following metrics in 2014/15:

- 90.3 per cent patient and caregiver satisfaction based on Client and Caregiver Experience Evaluation surveys conducted by third-party researchers
- 96 per cent of patients and caregivers would recommend our services to family and friends
- 24 per cent reduction in wait times for 9 out of 10 patients over the past three years
- 12 per cent readmission rate for medical and surgical patients (lowest in Ontario, tied with Waterloo Wellington CCAC) reported by HQO yearly report 2015

Quality Improvement Plan metrics based on MOHLTC indicators show we are among the top high-performing organizations achieving:

- 96.2 per cent of patients receive nursing within five-days
- 92 per cent of patients with complex care needs receive personal support within five days

Harnessing the strengths of the organization to deliver better care for patients

Informed by the Community Capacity Plan, staff, stakeholders, patients and families, the team launched the most significant advancement of care coordination in our organization’s history. Enhanced care coordination delivers consistent care to patients, through enhanced competencies, standardized processes, coordinated care planning, care conferencing, integration with primary care and uncovering all community resources to better care for patients.

With training complete for Community care coordinators, those teams are relocating in April 2016 to sub-LHIN neighbourhoods, armed with health equity data for the communities they support.

Contracted service providers will be carefully re-assigned in July 2016 to provide more consistent care experiences in sub-LHIN neighbourhoods, based on patients’ goals that form the basis of their care plan developed by care coordinators. Patients will now benefit from a single, or at most two, service providers delivering planned care.

That is how the Executive team delivers care to 47,000 patients.
The Mississauga Halton CCAC
Board of Directors

The Board

The Board of Directors is comprised of 12 volunteer members and two community members who were recruited based on geographic representation of the region and for their exemplary skills and governance experience.

Given the mission and role of our organization in health care delivery, in addition to the normal governance functions common to most service provider organizations, and with an operating budget of $160-million, the Board focuses on critical accountabilities.

1. Patient engagement
2. Advocacy
3. Oversight for patient care quality and safety

Board accountability for patient engagement has members meeting with and hearing directly from patients and caregivers. They review updates from our organization’s patient and caregiver advisory forum, Share Care Council; they assess patients’ positive and adverse events reviews; they examine the results of our Client and Caregiver Experience Evaluations; and they participate in our four annual Heroes in the Home celebrations held across the region.

The Board advocates on behalf of residents to promote the best interests of patients and families. As the second-lowest funded CCAC, for successive years, the Board has advocated for fair funding, sending letters to the Ministry of Health and Long-Term Care, as well as met with local Members of Provincial Parliament.

The Board provides governance oversight for Quality and Patient Safety. Members govern the care of 47,000 patients and the coordination of 2.5 million care visits to ensure the safety of all patients. The Board reviews our annual Quality Improvement Plan, balanced scorecard, enterprise risk management and other key performance indicators. The Board also collaborates with 25 community agencies in Synergy West GTA, creating the Community Quality Network to co-develop shared quality indicators across agencies that provide care to patients.

Three committees undertake the work of the Board: The Governance Committee, the Patient Care Quality Committee and the Audit and Resources Committee. All committees report to the full Board of Directors monthly to ensure it fulfills its accountabilities.

Since the creation of the Mississauga Halton LHIN/CCAC Joint Board Collaboration Committee in 2012, members are now focusing on the proposed structural changes outlined in the discussion paper, Patients First: A Proposal to Strengthen Patient-centred Health Care in Ontario.

The process

The Board of Directors approves and monitors the Balanced Scorecard, a performance measurement tool, as well as our Quality Improvement Plan indicators and quality measures as defined by Health Quality Ontario; it has governance accountabilities for our enterprise risk management plan and our Client and Caregiver Experience Evaluation surveys.

That is how the Board of Directors supports care to 47,000 patients.

Board contributes to 100 per cent Accreditation Canada rating

Successive Boards of Directors developed exemplary governance capabilities as was documented during The Board’s participation in our 2013 Accreditation Canada process, contributing to an exemplary status of 100 per cent and an outstanding Accreditation Canada report. Our organization’s unique strengths were recognized in several ways by Accreditation Canada. The report commends our Board for its “ongoing initiative to collaborate with the LHIN in an effort to identify areas of shared decision making between the MHCCAC and the funding authority.”

Accreditation Canada surveyors declared the MHCCAC Board of Directors “functions as an effective, forward looking governing body. Members are well informed of their roles and fiduciary responsibilities. The structural arrangement of the board and a review of the minutes of the various committees, validate the energy and commitment that has enabled the board to live their mission, vision and values.”

The surveyors added, “Models for quality improvement and risk management are in place and adherence is monitored. The Board and indeed the whole organization are commended for the comprehensive effort to keep their clients safe at home. The governing body receives regular reports and updates on measures related to client safety, such as data on client falls or medication reconciliation. The data is compiled at the organization level rather than at the program or team level, presenting a global picture of client safety in the organization.”
Direct reports to CEO and to the Mississauga Halton CCAC Board of Directors

Mississauga Halton CCAC Board of Directors

Dieter Pagani
Board of Directors, Board Chair

Caroline Brereton
Chief Executive Officer

Richelle Komes
Executive Coordinator to CEO, Administrative Lead & Governance Liaison

Nancy Gale
Associate Vice President, Strategic Communications & Partnership Advancement

Angela Burden
Vice President, Regional Programs & Strategic Development

David Fry
Vice President, Patient Care

Jutta Schafler Argao
Vice President, People & Quality

Jim Wright
Vice President, Corporate Services

Mark Ratner
Ombudsperson, Privacy & Ethics Officer

31
Our Access Care Team is available from 8:30 a.m. to 9:00 p.m.

We have offices and staff located in the following hospitals. No referral is required to contact them.

**Trillium Health Partners (THP)**
Mississauga Hospital, Queensway Health Centre, Credit Valley Hospital

**Halton Healthcare Services (HHS)**
Oakville Trafalgar Memorial Hospital, Georgetown Hospital, Milton District Hospital

**310-2222 (CCAC)**
no area code required

www.healthcareathome.ca/mh

www.mississaugahaltonhealthline.ca